



Your emergency care summary

NHS Summary Care Record Guide for GP Practice Staff

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1 Introduction to this guide

This guide is intended to provide all GP practice staff with an awareness of what the Summary Care Record (SCR) is and the role that GP practices play in creating the SCR and supporting patients.

Training arrangements will vary between Primary Care Trusts (PCTs) and this guide is not intended as a replacement for face to face engagement activity or system training. It is, however, intended to act as a useful additional source of information and aims to cover the minimum that staff will need to know prior to implementing the SCR.

Further information and relevant guidance on all the areas covered in this guide can be found on the SCR website at <http://www.connectingforhealth.nhs.uk/systemsandservices/scr>.

The guide covers the following:

- Overview of the SCR
- Informing patients
- Creating and maintaining records (including managing patients' SCR consent preferences)
- Practice readiness
- Support for GP practice staff

2 Overview of the Summary Care Record (SCR)

2.1 What is the Summary Care Record?

The SCR is an electronic patient summary containing key clinical information from the GP record that is accessible by authorised healthcare staff in an urgent or emergency situation. An SCR is optional - a patient can choose whether or not to have one. Furthermore where a patient has an SCR it should only be accessed with permission from the patient except in exceptional circumstances, for example, emergency access if the patient is unconscious.

2.2 Core Information

An SCR is made up of the following core patient information:

- Medications (Acute, Repeat and Discontinued Repeat)
- Allergies
- Adverse Reactions

This information is shared from the GP practice IT system when a practice 'goes live' with SCR. Following this initial upload of patient information the SCR will be updated whenever there are changes made to medications, allergies or adverse reactions in the GP practice IT system by a user who is logged in with an NHS smartcard.

2.3 Additional Information

Additional clinical information over and above the core information, for example, significant diagnoses or care plans, can be added to the SCR by a patient's GP practice where the patient and the GP agree that adding further information may be beneficial to the patient. Patients are in control of any additional information and are required to give explicit consent to additional information being included. More information can be found in section 4.3.

2.4 Using the SCR to support patient care

When patient information has been uploaded to the SCR it can be made available, with the permission of the patient, to authorised healthcare staff in urgent and emergency care settings outside of the GP surgery, for example, in Accident and Emergency departments or Out of Hours services to support patient care. (Appendix D provides more information on how patient information is protected).

As GP IT systems develop, GP Practices will be able to view the SCR to support the care of temporary residents. More information on the SCR enhancements that are being introduced to GP IT systems, including this functionality, can be found at:

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/gppracinfo>

Information and case studies about how SCR is being used to support patient care including emerging benefits can be found at:

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/aboutscr/benefits>

3 Informing Patients

3.1 Public Information Programme

In order to inform patients about the introduction of the Summary Care Record (SCR), a Public Information Programme (PIP) will take place. The PIP is an information programme co-ordinated by the PCT to inform patients and NHS staff about the SCR and the choices available to patients.

Each patient aged 16 and over, or due to turn 16 during the public information period, will be sent an individual patient information pack. Each patient information pack contains:

1. Letter from the PCT
2. Patient summary leaflet
3. Freepost opt-out form

Further awareness is raised through local community awareness programmes, media and public relations activity. Patients are also signposted towards local information, for example, PALS, the PCT, local websites and GP practice staff.

Patients can also visit the national patient website or contact the Summary Care Record Information Line (0300 123 3020) for further information.

A PIP toolkit including template materials and resources is available from:

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/aboutscr/comms/PIP>

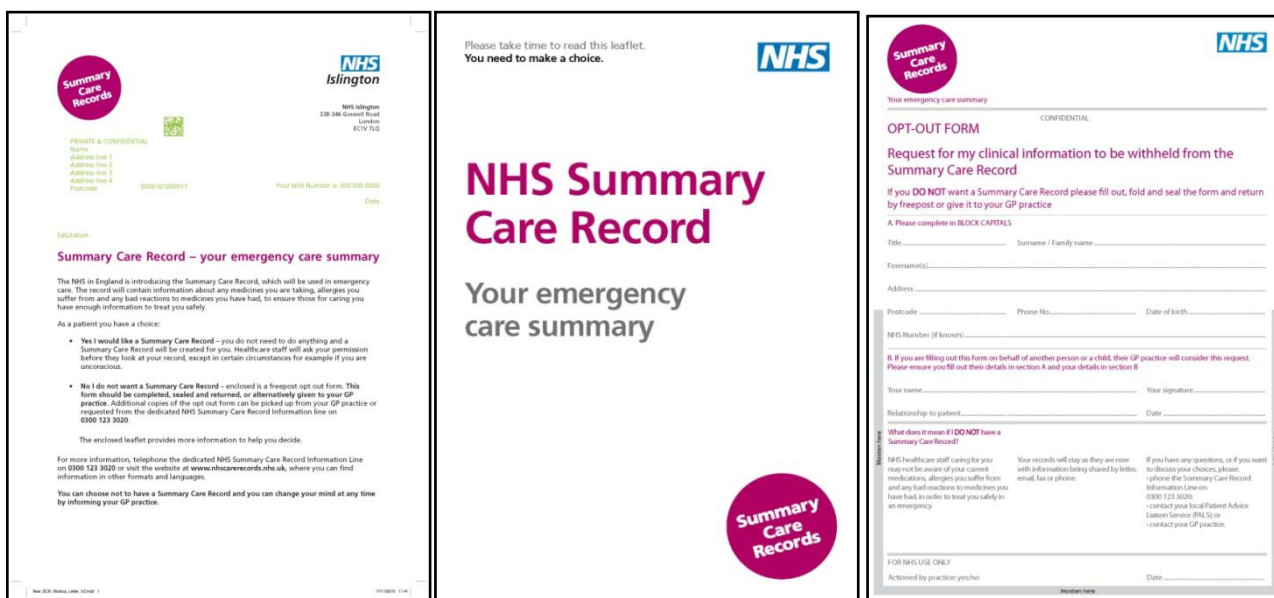


Figure 1 – Patient information pack contents

3.2 Assisting patients with their choices

Patients are able to choose whether or not they wish to have an SCR and some may require assistance in making that decision.

The patient information pack, sent to patients as part of the PIP, will advise patients that they have a period of time to decide whether they wish to have an SCR created for them.

If patients are not sure whether they wish to have an SCR, they will be encouraged to seek further information and support and are signposted to various other sources of information to help them make their decision including:

- Visiting the patient facing SCR website at www.nhscarerecords.nhs.uk
- Contacting their local Patient Advice and Liaison Service (PALS) www.pals.nhs.uk
- Contacting the Summary Care Record Information Line on 0300 123 3020 (which includes a translation telephone service)

3.3 Patient choice following being informed about SCR

Following the receipt of an information pack about the SCR patients have a **minimum** of 12 weeks to make their choice before their GP practice can start creating records for them (under the model of informed implied consent):

- If a patient wishes to have an SCR, they are **not** required to take action and one will be created for them
- If a patient does not want an SCR they are instructed to complete an opt out form which needs to be returned to their GP practice

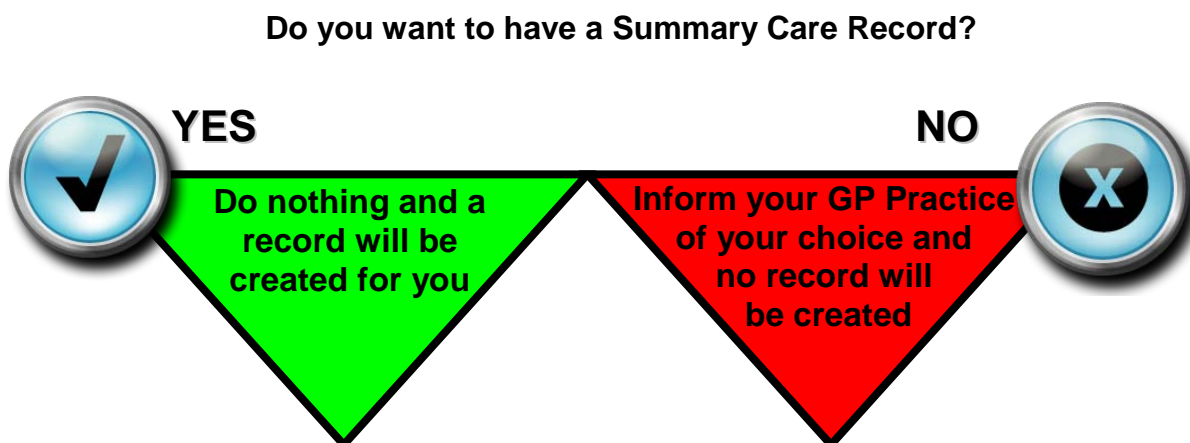


Figure 2 – SCR Consent

3.4 Opting out

Patients can **opt out** of the SCR by informing their GP Practice and completing an opt out form. From December 2010, freepost opt out forms are included in the patient information pack. Patients can also obtain opt out forms at their GP practice, from the patient website or can request one from the Summary Care Record Information Line. The GP Practice should record the patient preference in their GP IT system (see section 4)

Patients can choose to opt out at any time, even after the SCR has been created.

If a patient chooses to opt out, an SCR that may have previously been created is no longer able to be viewed by healthcare professionals.

It is also possible for a patient to request that an SCR that has been created for them is deleted. Further details of how such requests are processed can be found on the SCR website.

3.5 Patient choice about including additional information in their SCR

Patients can choose to have additional information included by their GP Practice in their SCR. This can be done where both a patient and clinician feel there may be benefit to the patient in having additional information available to other clinicians in urgent and emergency care settings. For example, patients with an End of Life care plan may wish to add this information to the SCR to be available in the event of them receiving urgent or emergency care. More information on additional information can be found in section 4.3.

3.6 Patient choice at the point of care – Permission to View

In addition to being able to choose whether or not they have an SCR, patients are also asked for their permission each time the record is viewed. This is known as 'permission to view'.

In an emergency where it may not be possible to ask the patient, for example if they are unconscious, a clinician may view the record without asking in the patient's best interests. All such actions will be recorded for investigation.

Can I look at your SCR?



Figure 3 – Permission to View

4 Creating and Maintaining Records

4.1 Creating and Updating SCRs

In order to send patient information to the SCR a GP practice requires a technical upgrade to their GP practice IT system which is undertaken by their system provider. A GP practice will only start creating SCRs, or 'go-live', when:

- There is agreement between the GP practice and the PCT to take part
- There is agreement between the GP practice and the PCT that patients have been adequately informed about the process and properly enabled to opt out should they wish
- The GP practice have an IT system that is ready to send information to the SCR i.e. it has been upgraded by their system provider

Within each PCT there will be an SCR lead who will work with GP practices to ensure that the relevant implementation activity takes place prior to going live with SCR. On going live an initial upload takes place to generate an SCR for every fully registered patient who has not chosen to opt out of having an SCR. This process will result in the creation of the patient's core SCR containing a record of their medication, allergies and adverse reactions. Any patient record that is marked as FP69¹ will be excluded from the upload and these patients will not have an SCR created for them.

After the initial upload of information to the SCR, the record is updated in the following ways:

- Every time a change is made to the core information
- When additional information is selected to be included, for example, a diagnosis is marked to be included in the patient's SCR. This can only happen if the patient is set to explicit consent on the GP practice IT system.

The SCR is date and time stamped so that anyone viewing the SCR knows the date and time that information was last sent to the SCR.

4.2 Recording patient preferences

Patient preferences about whether or not they want an SCR and whether they would like additional information included are recorded on the GP practice IT system. This can be done in two ways:

1. By adding the relevant code manually to a patient's record. This can be done at any time on any GP practice IT system. GP Practices should follow the guidance in this section regarding which codes to use.
2. By using the GP practice IT system's SCR consent management screens. This option becomes available once your practice IT system has been upgraded for SCR.

Recording patients' preferences on the GP practice IT system enables the system to control the flow of information to the SCR in accordance with the patients' wishes.

SCRs are created under a model of informed implied consent. When a practice goes live with the SCR and no preference has been expressed, an SCR is created for a patient containing core information of medications, allergies and adverse reactions.

In order to add additional information to a patient's SCR, over and above the core information, all systems require a patient's consent preference to be changed to **explicit consent**. The explicit consent setting should only be used when a patient wishes to add additional information to their SCR (see section 4.3)

¹ An FP69 status is attached to a patient where there is some doubt as to whether a patient is still resident within the area covered by the GP practice (see section 5.1 for more information).

In each case, only the most recently recorded preference will be used to control the flow of information to the SCR.

4.2.1 SCR Consent Preferences

Currently, GP practice IT systems have the following consent settings that control the flow of information to the SCR:

- No preference expressed (implied consent)
- The patient wants to have a Summary Care Record (explicit consent)
- The patient does not want a Summary Care Record (opt-out)

Following close collaboration between NHS Connecting for Health, the BMA and RCGP, four new SCR Patient Consent Preferences were introduced as part of the bi-annual release of UK clinical codes in April 2011². These support GP Practices to more accurately reflect patients' wishes and provide clearer information to GP Practices on the effect of each preference on the content of the SCR. They support patients who wish to change their preference including those who have previously opted out but subsequently decide that they wish to have an SCR containing only core information

The new SCR Consent Preferences are:

- Implied consent for medication, allergies, and adverse reactions only
- Express consent for medication, allergies, and adverse reactions only
- Express consent for medication, allergies, adverse reactions AND additional information
- Express dissent (opted out) - Patient does not want a Summary Care Record

Currently four GP IT systems are able to create and send SCRs. These are EMIS LV, INPS Vision, TPP SystemOne and iSOFT Synergy. Whilst these preferences and codes may be available in these GP IT systems now, the GP IT system will require an upgrade for these codes to be activated i.e. to recognise and control the flow of information to the SCR³. Until you are notified that your GP IT system has been upgraded, you should continue to use the existing preferences and codes to control the information sent to the SCR. GP Practices who are using GP IT system supplier products that are not yet able to send SCRs should use the new SCR consent codes, where available, to record patient preferences.

² For more information see 'Introducing the new Summary Care Record Consent Codes' at: <http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/gppracinfo>

³ EMIS LV, INPS Vision and TPP SystemOne are currently testing their upgraded systems containing the activated new SCR consent preferences and codes. It is anticipated that each of these systems will be available in early 2012. Suppliers will communicate to GP Practices when these systems are ready. Quick references guides for these upgraded systems will be produced and will be found at: <http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/gppracinfo>

SCR communiqués will be sent out as the new systems are ready. GP Practices can sign up to receive the new communiqués via the above webpage.

4.2.2 Coding patient preferences

The default setting in the GP Practice IT system for patient records is implied consent which allows the flow of core data only to the SCR. The following tables detail the old and new SCR Consent Preferences with their associated codes and terms; and the effect each preferences will have on the content of a patient's SCR:

Current SCR Consent Preferences			Effect on the content of a patient's SCR
Wording on SCR Patient Consent Preference management screen	Code Read 2 CTV3	Code Term	
No preference expressed (only allergies and medications will be uploaded whilst this setting persists)	This preference does not have a code or code term.		The SCR will only contain medication, allergies and adverse reactions.
Patient wants a Summary Care Record	93C2. XaKRx	Consent given for upload to national shared electronic record	Allows additional information to be sent to the SCR (see section 4.3)
Patient does not want a Summary Care Record	93C3. XaKRy	Refused consent for upload to national shared electronic record	Sends a blank summary to the SCR (Patient opted out)

New SCR Consent Preferences			Effect on the content of a patient's SCR when these preferences/codes are activated
Wording on SCR Patient Consent Preference management screen	Code Read 2 CTV3	Code Term	
Implied consent for medication, allergies, and adverse reactions only	9Ndl. XaXbX	Implied consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.
Express consent for medication, allergies, and adverse reactions only	9Ndm. XaXbY	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.
Express consent for medication, allergies, adverse reactions and additional information	9Ndn. XaXbZ	Express consent for core and additional SCR dataset upload	Allows additional information to be sent to the SCR (see section 4.3)
Express dissent (opted out) - Patient does not want a Summary Care Record	9Ndo. XaXj6	Express dissent for SCR dataset upload	No SCR will be available as the patient has opted out

4.2.3 Consent management screens

Patient preferences can be recorded through the SCR Consent management screens within GP practice IT systems following the system upgrade to switch on the SCR. Recording consent through the consent management screen adds the corresponding Read code into the patient’s record. The below figure shows an example of this screen in current GP IT systems with the SCR consent management functionality in the bottom half:

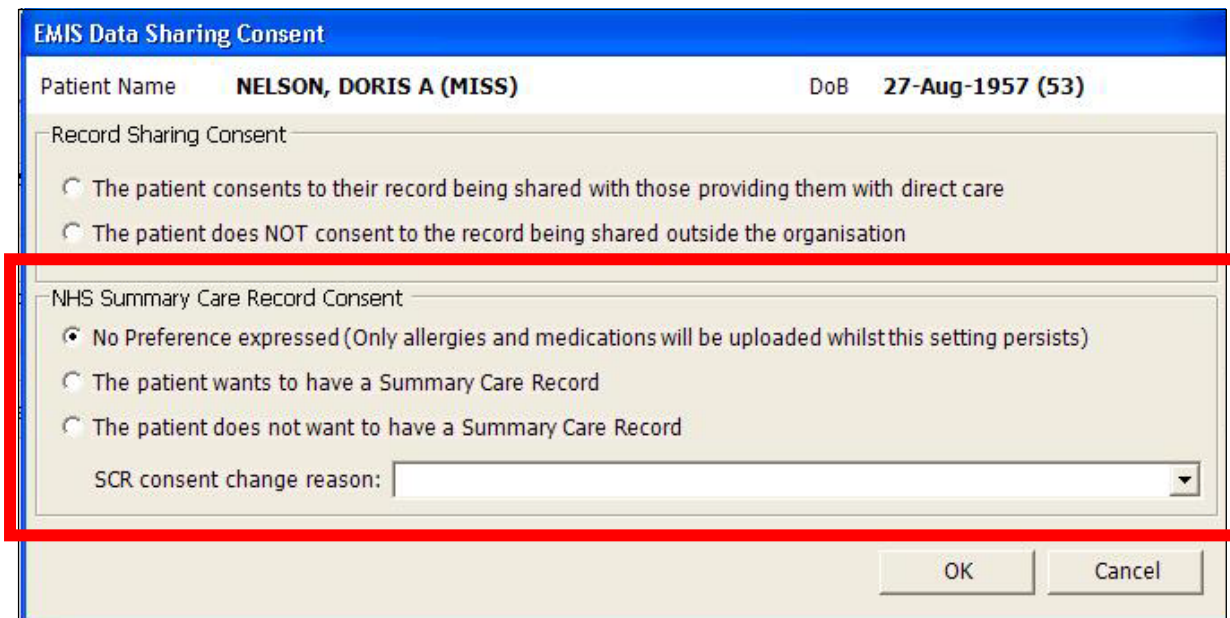


Figure 4 – An example of an SCR Consent management screen in current GP IT systems

The below figure shows an example of the SCR Consent management screen for GP Practices who have been notified by their system supplier that the new SCR consent preferences and codes are activated i.e. can recognise and control the flow of information to the SCR:

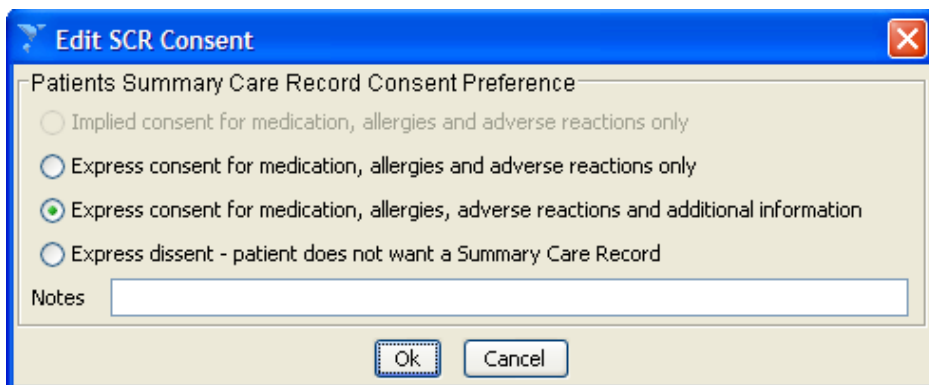


Figure 5 – An example of an SCR Consent management screen where the new SCR Consent preferences are activated

4.3 Additional information

Additional information can only be added to the SCR where a value of **explicit consent** is set on a patient's record. The explicit consent setting only needs to be set once for a patient and does not need to be set each time an additional information item is added to the SCR.

There are two ways in which additional information can be added to a patient's record:

1. By a GP Practice selecting additional items to include on a patient's SCR (where **explicit consent** has been set). Each GP IT system contains functionality to support this.
2. By problem or diagnosis information being sent to the SCR to display under the "Reason for Medication" heading:
 - a. This happens where a coded problem or diagnosis is linked to a repeat medication in the GP practice IT system.
 - b. For three out of four systems currently compliant with SCR⁴ this information flows automatically where a setting of **explicit consent** is present on a patient's record (see Appendix B for more details).
 - c. In future versions of SCR-compliant GP IT systems, reason for medication will only be included if the coded reason is specifically selected to be included. Your GP IT system supplier will let you know when this is being introduced in your system⁵.

Guidance is available to support GP practices in understanding additional information including the principles for implementing explicit consent for additional information and how to add additional information in each GP IT system. This guidance can be found at:

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impquidpm/createscrs/additional>

4.4 Changing consent preferences

Patients can change their SCR consent preferences at any time. However once a patient has either opted out of having an SCR or has explicitly consented to having an SCR, in line with good record keeping, patients should not be returned to a status of 'no preference expressed' (implied consent). There is one exception to this and this is discussed in section 4.5

In GP Practices that have been notified that the new SCR Consent preferences are activated in their system, it will be possible to change the patient's consent preference to any of the express consent or dissent preferences including reverting a patient back to a core record through using the 'Express consent for medication, allergies and adverse reactions' preference. Appendix A contains example wording for a form that could be used to support a patient change their consent preference.

In GP Practices who have not yet been notified by their systems supplier that the new SCR consent codes are activated in their system, it will not be possible to revert a patient back to having a core record only (until their system is upgraded to recognise the new SCR Consent preferences). GP practices should be mindful of this and may need to discuss with patients the options available after either opting out or explicitly consenting to additional information being added to their SCR. Sections 4.4.1 and 4.4.2 below explain this in more detail. Appendix B contains system specific detail on how to manage patients SCR consent preference in current SCR compliant GP IT systems.

⁴ In INPS Vision, iSOFT Synergy and TPP SystmOne 'Reason for Medication' flows automatically where explicit consent is set. Further steps are required on EMIS LV. (See Appendix B for further system specific information).

⁵ An overview of the SCR enhancements to GP IT systems that will be introduced can be found at: <http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/gpracinfo>

4.4.1 Patient options after choosing to opt out of the SCR (for GP systems where the new SCR consent codes are not yet activated)

Where a patient has opted out from having an SCR, then the patient's record will contain the 93C3 Read code (or XaKRy in CTV3).

If a patient wishes to change this preference and have an SCR, this will require them to be set to **explicit consent**. This can be done by adding a 93C2 (or XaKRX in CTV3) into their record or by changing their setting to 'Patient wants a Summary Care Record' in the consent management screen. Changing the setting to explicit consent will allow additional information beyond the core information to be sent to the patient's record. In particular this may include Reason for Medication, by default. Any additional information above this would only be added to the SCR with the patient's explicit consent, by their GP Practice.

If the patient is not happy with the implications of changing their consent preference to explicit consent then the patient should remain opted out of the SCR until such time that the new SCR Consent preferences are activated in the GP IT system which will enable the patient to express a preference for core information only.

It is recommended that practices note the outcome of this discussion in the patient's GP record.

A factsheet has been produced to help GP Practices staff support patients who want to opt back in to the SCR after previously opting out (see Appendix C).

4.4.2 Patient options after explicitly consenting to the SCR (for GP systems where the new consent codes are not yet activated)

Where a patient has consented to additional information in their SCR then the patient's GP record will contain a 93C2 Read code (or XaKRx in CTV3).

If a patient wishes to opt out of the SCR this can be done by adding a 93C3 (XaKRy in CTV3) or by changing their preference to 'Patient does not want a Summary Care Record' in the SCR consent management screen.

Where a patient had previously expressed a preference to have additional information in their SCR and now wish to retain an SCR with core information only, the GP should inform the patient that no additional information other than Reason for Medication will be added to their record without their consent. Any existing items which had previously been added to their SCR can be removed at their request. In the scenario where a patient does not want Reason for Medication to be sent to the SCR, or does not want a setting of explicit consent to be retained on the system, the GP should opt out the patient from having an SCR until such time that the new SCR Consent preferences are activated in the GP IT system which will enable the patient to express a preference for core information only.

It is recommended that practices note the outcome of this discussion in the patient's GP record.

4.5 Managing inappropriate use of the current explicit consent preference

Prior to the introduction of the new SCR consent codes, the explicit consent preference may have been used by GP Practices in one of the following scenarios:

- a) To allow additional information to be added to the SCR where a patient has explicitly consented to additional information.
- b) To allow additional information to be added to the SCR without the explicit consent of the patient. This may have occurred before the requirement to seek explicit consent from a patient for additional information was introduced.
- c) To opt back into the SCR after opting out. This may have occurred as part of the new patient process where a patient has been opted out to allow them more time to consider their options.

- d) In error. For example, where a mistaken assumption has been made that the explicit consent setting is required for an SCR to be uploaded.

GP Practices should have been assisted by PCTs following the 2010 Ministerial Review of the Summary Care Record to perform the below process to ensure that additional information is only added to a patient's SCR where they have explicitly consented and that the explicit consent preference is used appropriately:

- Identify all patients who are set to the explicit consent (93C2. or XaKRx) in the GP IT system
- For these patients, as a one off exercise, establish whether each patient does consent to additional information in their SCR.
- Where the explicit consent setting does not correctly reflect the patient's preference (i.e. in scenarios b, c and d), practices should have amended the SCR to hold only core information. This can be achieved in the current GP IT systems by deleting the 93C3. or XaKRx code which will revert the patient to implied consent. Practices are advised to consult page 172 the 'Good Practice Guidelines for GP electronic records V4 for guidance regarding the amendment of patients' medical records (see Appendix E).

5 Practice Readiness

5.1 Practice Readiness Activities

In preparation for going live with SCR and following go-live there are a number of activities that need to take place and processes to be established. PCTs and GP practice IT system providers will work with practices to support implementation activities at each practice.

- **Training**

As part of preparation and implementation activity staff will be trained on the concepts of the SCR. This will help ensure that staff understand the supporting processes around the adoption of SCR within the practice and ensure that staff are fully equipped with the knowledge required to deal with patient enquires. Training may take the form of specific practice training sessions or may take place over a series of practice visits. Each PCT will tailor their approach depending on the needs and constraints of each practice.

Additionally, GP practice IT system suppliers will schedule system training with the practice to coincide with the technical upgrade of the system.

- **Materials to support patients**

Practice staff will have received information to enable them to deal with any queries patients may have about the SCR. Information for newly registered patients should be available in the practice to give to new patients that register with the practice. Practice staff should know where to go for further information should they receive a query from a patient that cannot be answered. In these cases staff are able to direct the patient to the Summary Care Record Information Line (0300 123 3020). Alternatively, staff can contact their PCT for additional guidance.

- **Technical upgrade activities**

All of the appropriate technical checks will be carried out by the GP practice IT system provider and PCT. Access to the IT system will be required and a point of contact will need to be available to help co-ordinate technical upgrade activities.

- **Managing the Personal Demographics Service (PDS) information**

Some practices may already have PDS functionality. PDS functionality ensures that the demographic details (name, address, telephone number etc) which a practice holds about patients are synchronised with the details held nationally. Practices will be responsible for checking what are the most up to date and complete details. If PDS functionality is not already in place, it will be implemented when their GP practice IT system is upgraded to go-live with the SCR.

In order to send clinical information to the SCR your GP practice IT system and the PDS must synchronise to identify the correct patient. Where discrepancies arise they will need to be resolved prior to clinical information being sent to the SCR. There are activities that can be undertaken prior to going live which will help minimise the number of PDS discrepancies. Your PCT and GP IT system supplier will be able to assist and advise you with these activities and help ensure that you have ongoing processes in place to manage maintaining good quality demographic information.

- **Smartcards**

Many practices are already using smartcards for existing applications that connect to national systems. NHS smartcards are required for sending information to the SCR. Practices therefore, must follow any processes that are explained during the supplier training in relation to the use of smartcards.

Practices should ensure that they have processes in place in conjunction with the PCT for the issuing and use of smartcards including the allocation and use of smartcards by locum GPs.

- **Information fit for sharing through SCR**

GP Practices have a responsibility to ensure that the clinical information they hold about patients is of the best possible quality to inform their clinical care. This responsibility is underpinned by professional regulatory guidance, statutory requirements and pan-professional guidance. The SCR will be used as an information source to support care in urgent and emergency situations. It should be recognised that these users of the SCR will not have access to the whole source GP record or, in most cases, familiarity with the patients concerned. The quality of information contained within a patient's SCR is a reflection of the quality of the information in their GP electronic patient record.

Therefore, as part of the process for being ready for SCR, a GP practice will need to confirm that their data is fit for sharing through the SCR. PCTs will work with practices to assess and, if required, assist in improving data quality.

For more information and guidance on establishing that the information GP Practices will share through the SCR is fit for sharing please see:

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/dq/index.html>

Additionally, the 'Good Practice Guidelines for GP Electronic Patient Records v4, 2011', provides practices with further information (see Appendix E).

- **Handling Returned Mail**

In order to ensure that SCRs are only created for patients who have been informed about the SCR, any patient record that is marked as FP69 will be excluded from sending information and these patients will not have a SCR created for them.

PCTs and practices will ensure there is a process in place to manage any PIP letters that are returned undelivered. There are two options for dealing with returned mail:

- 1) Returned mail to be managed by the PCT in the normal way (i.e. through the FP69 process). These patients will not have an SCR created for them unless the practice checks and resets the registration status before the upload takes place.
- 2) Information is sent to GP practices to individually manage the status of their patients. Practices then ensure that patients are appropriately informed or excluded from the upload.

- **Managing new patients**

Patients registering at a GP practice following the creation of the PIP mailing list will need to be informed about the SCR and have the opportunity to opt out should they wish to do so. Practices need to have processes in place for capturing and managing new patients' preferences.

Each new patient should receive information about the SCR (a letter is available at <http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/newpatients> and an opt out form) together with a practice's new patient registration form. The patient is then able to decide whether or not they would like to have an SCR. Their options are:

- **Yes**
- **No** - the patient informs the practice of their decision and completes an opt out form.
- **More time required** – the patient may wish to take time to consider their options.

The action taken by the practice depends on the patient's decision and whether the new SCR Consent codes are activated in their system. The table below explains this in more detail:

		GP Practice actions	
		Current (old) SCR consent codes are being used	New SCR Consent codes are activated and being used to control the flow of information to the SCR
Patient's decision	Yes	No action required by the GP Practice	GP Practice staff record in the GP IT system the appropriate patient preference: 'Express consent for core SCR dataset upload' Or 'Express consent for core and additional SCR dataset upload'
	No	GP Practice staff record in the GP IT system using the appropriate old code	GP Practice staff record in the GP IT system using the appropriate new code
	More time	GP Practice staff should record in the GP IT system that the patient has opted out of the SCR by entering the appropriate old code. A recall should then be set in the system to remind staff to contact the patient to seek a decision (a recall of one month is recommended). If a patient then decides that they would like an SCR they are able to opt back in and have a record created (see section 4.4.1 for further details).	GP Practices staff should record in the GP IT system that the patient has opted out of the SCR by entering the appropriate new code. A recall should then be set in the system to remind staff to contact the patient to seek a decision (a recall of one month is recommended). If a patient then decides that they would like an SCR the GP Practice should enter the appropriate express consent preference.

The patient's decision as to whether they would like an SCR should be recorded as part of the practice's new patient registration process. Nationally, the processes that are in place for new patients vary across practices. Some use the GMS1 form to record patient registrations and others use their own local variations:

- GMS 1 form – where practices use a GMS1 form to register patients it is recommended that an additional form is attached to the GMS1. The additional form will require a patient to state their decision.
- Local registration form – where local variations of the GMS1 are being used it is recommended that an additional question is added to the form to allow the patient to state their decision.

An alternative approach to managing new patient SCR consent preferences is to wait and introduce the new registration process at the time the practice creates records. In this case the practice would need to run a search on the GP clinical system to find all patients who have registered from the date when the initial PIP mailing list was created to the date when a practice does their initial upload of patient data to the SCR.

This would generate a list of patients who will not have been directly informed about the SCR. The GP practice or PCT would need to write to these patients to provide them with the information needed about the SCR. The disadvantage to this process is that PCT / GP practices would incur additional costs in sending letters to this group of newly registered patients, particularly for practices with high list turnover. Thereafter the new patient process would need to be adopted to ensure new patients registering with the practice are informed about the SCR.

- **Supporting Children and Vulnerable Adults**

Children get an SCR but do not get a letter informing them about the SCR. Where the child lacks Gillick competence and a parent wishes to opt them out then they should make this request on behalf of the child. Where a child may have Gillick competence and they wish to opt out, then they should inform their GP of their request. In most circumstances where a request to opt out a child has been made, then that request will be actioned, however there may be specific circumstances where the GP feels that the best interests of the child concerned may justify the creation of an SCR.

Vulnerable adults are supported in exactly the same way as they are supported for any other medical process.

GPs should also refer to existing guidance and legislation, such as GMC guidance, to support children or patients who may lack capacity.

- **Recording Patient Choices**

Practices should have processes in place to record a patients SCR preference. Details of this are described above in section 4.2.

- **Nominating a practice expert**

Some practices have found benefit in having a member of staff who acts as an SCR expert to help deal with complex queries and support other practice staff.

- **HealthSpace**

Patients are able to view their SCR online through HealthSpace. HealthSpace is an online personal health organiser which allows patients to keep track of their health information.

All patients over 16 years old, in England, can currently register for a HealthSpace account. In order for patients to view their SCR view HealthSpace they need to be registered with an advanced account. Advanced account registration is being implemented by local NHS organisations. Alongside this GPs can support patients to obtain a HealthSpace account using a Clinical Vouch for Identity Form which can be found on the HealthSpace website.

PCTs will be able to provide more information to practices on local plans for implementing advanced account registrations.

To learn more about HealthSpace visit

<http://www.connectingforhealth.nhs.uk/systemsandservices/healthspace>

5.2 PCT Responsibilities

With the guidance of their SHA, each PCT will be responsible for supporting their GP practices and ensuring that patients registered with a GP practice receive appropriate information about the SCR and the choices they have.

PCTs will also advise local voluntary sector organisations of the changes and potential impact of the SCR implementation and ensure that they are well enough informed to manage any queries and meet the information requirements of their service users.

The level of support provided by the PCT to each GP Practice may vary but can consist of any or all of the following:

- project management for the SCR implementation
- manage the GP Practice IT system supplier relationship on behalf of the practice
- provision of trainers or project managers to cascade training to all relevant personnel
- assistance from fully trained staff in the implementation of the SCR
- knowledge of and access to all to the information resources and tools available

PCTs may also request each GP practice to agree to a memorandum of understanding or acceptable user policy at the start of implementing SCR within a practice. This would help clarify the roles that the PCT and practice play and the responsibilities of each. Further guidance on developing an acceptable user policy can be found at

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/projmgmt>

5.3 Practice Checklist

The following checklist can be used by practices to help ensure they have the appropriate information, materials and process in place to support rollout of the SCR. It is to be used to support two-way communications with PCT SCR project teams and practice staff.

1	Have you received a letter or a visit to your practice from your PCT explaining the SCR project and rollout timetable?	Yes/No
2	Has your PCT provided any further engagement opportunities for GP practice staff or have you been offered or received any SCR training or awareness sessions for the practice?	Yes/No
3	Do you have enough information to assess or confirm whether your data is fit for sharing?	Yes/No
4	Have you received SCR communications materials for your GP practice, including posters, new patient information packs and opt out forms?	Yes/No
5	Do you have enough information to be able to respond to patient queries about the SCR?	Yes/No
6	Are you able to signpost patients to further information points, including the national Summary Care Record Information Line or your local information services, e.g. PALS?	Yes/No
7	Do you know how to process completed opt out forms and understand when and how to record consent preferences?	Yes/No
8	Do you understand the conditions under which additional information above the core or medications, allergies and adverse reactions can be added to the SCR i.e. only with the explicit consent of the patient?	Yes/No
9	Have you understood and agreed the process with your PCT for managing returned mail?	Yes/No
10	Have you got a process in place for informing patients about the SCR as part of the new registration process?	Yes/No
11	Has your PCT arranged patient awareness sessions?	Yes/No
12	Has your PCT planned any other forms of public awareness, for example a local media campaign? If so, has the practice received copies of any press releases issued?	Yes/No
13	Has your PCT provided guidance to your practice on how to manage media enquiries and requests for information about the SCR?	Yes/No
14	Are there processes in place for the prompt allocation and use of smartcards within your practice and does your PCT have support processes in place to deal with any smartcard related problems?	Yes/No

6 Support for GP Practice Staff

6.1 Local Project Teams

The first point of contact for GP practice staff should be their PCT SCR project lead.

Additionally, each SHA has an SCR lead who is responsible for the overall implementation within the SHA. Details of each SHA lead can be found at

www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/aboutscr/ni/index.html

Further assistance and subject matter expertise is available from the NHS Connecting for Health SCR Implementation team at

www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/aboutscr/jiteam

6.2 Summary Care Record Website

A range of additional information is available to support you on the SCR website. The website contains implementation guidance, communications materials, training materials and background to the SCR. Staff are encouraged to visit the website for further information on any of the areas covered in this guide.

The SCR website can be accessed at:

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr>

Additionally, there is a dedicated patient facing website that patients can be directed towards to find further information about the SCR. This can be found at <http://www.nhscarerecords.nhs.uk>

6.3 Summary Care Record Communiqués

As new guidance or implementation updates are available concerning the SCR programme, email updates are sent to a distribution list. These are known as SCR Communiqués. Anyone involved with the implementation of SCR within their organisation may find communiqués useful.

To subscribe to SCR communiqués visit

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/communiqués/index.html>

6.4 General Enquiries

General enquires about the SCR programme can be directed to CFH.SCR-enquiries@nhs.net.

6.5 Training for the SCR

Training guides, materials and information can be found on the SCR website at

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/training>

These materials include web-based learning tools that can be used to train GP Practice staff such as new starters who may have missed initial training prior to go-live.

6.6 NHS SCR Information Line

This is for patients requiring further information about the SCR, (including copies of the SCR leaflet in other languages and accessible versions). GP Practice staff are able to refer patients to the Summary Care Record Information Line on **0300 123 3020**. The line is open Monday to Sunday between the hours of 8 am and 8 pm, except Bank Holidays.

The Summary Care Record Information Line has translation and text phone services. Please note that the information line is for patients and members of the public only.

6.7 Patient Advisory Bodies

Where patients wish to discuss the SCR in more detail you may also recommend that they seek advice from any local patient advisory body such as the Patient Advisory Liaison Service (PALS).

6.8 Business Process Maps and Protocols for Managing Clinical Scenarios

The introduction of the SCR will result in changes to current business processes within a GP practice. A range of suggested business process maps and protocols have been developed to provide assistance to staff to understand the processes which either support the SCR or are affected by the introduction of the SCR.

The maps and protocols cover a number of scenarios. These can be accessed at www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/buspromaps

Appendix A: Example content for a form to support patients who wish to change their decision about their SCR

Patients can change their SCR consent preference at any time. In GP Practices that have been notified that the new SCR consent preferences are activated in their system, it will be possible to change the patient's consent preference to any of the express consent or dissent preferences. The following wording could be used by these GP Practices to develop a form for the practice to use to support patients who wish to change their decision about their SCR consent preference.

Form to support patients who wish to change their decision about their SCR

A. Please complete in BLOCK CAPITALS

Title
Surname/Family name
Forename (s)
Address
Postcode
Phone no
Date of birth
NHS number (if known)

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name
Your signature
Relationship to patient
Date

C. I wish to change my decision about my Summary Care Record.

I would like (please tick one):

- A Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had
- A Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had AND any other information that I have agreed with my GP Practice to have included in my Summary Care Record
- I do not want to have a Summary Care Record (opt out)

Appendix B: Managing patient SCR consent preferences in GP practice IT systems where the new SCR consent codes are not yet activated

The guidance on the subsequent pages is **only** for GP Practices where they have **not yet** been notified by their systems supplier that the new SCR consent codes are activated i.e. can recognise and control the flow of information to the SCR.

Please note: EMIS LV, INPS Vision and TPP SystmOne are currently testing their upgraded systems containing the activated new SCR consent preferences and codes. It is anticipated that each of these systems will be available in early 2012. Suppliers will communicate to GP Practices and an SCR communiqué will be sent when these systems are ready. Quick references guides for these upgraded systems will be produced and can be found at:

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/gppracinfo>

Therefore this guidance is included to support GP Practices in the interim period until the upgraded systems are available.

EMIS LV

Patient preference can be set by either using the radio buttons in the SCR consent management screen or by adding the relevant Read code. The most recent preference that is present in the system is used to control the flow of information to the SCR.

The setting of 'The patient wants to have a Summary Care Record' (Read code 93C2.) should only be used where the patient has explicitly consented to have an SCR with the potential for additional information to be added to their record. Reason for Medication will be sent to the SCR where a problem is linked to a medication and the problem is marked for inclusion to the SCR.

Managing patient preferences using the consent management screen

The default setting is 'No preference expressed'. Once a preference has been set you **cannot** revert back to 'No preference expressed' using the radio buttons as this option is greyed out. It is possible to switch between 'The patient wants a Summary Care Record' and 'The patient does not want a Summary Care Record' and vice versa using the radio buttons.

Managing patient preferences using Read codes

Read codes can be used to set patient preferences using the following:

Consent Preference	Read 2	Code Rubric	System Action
The patient wants to have a Summary Care Record (explicit consent)	93C2.	Consent given for upload to national shared electronic record	Allows additional information to be sent to the SCR
The patient does not want to have a Summary Care Record (opt out)	93C3.	Refused consent for upload to national shared electronic record	Sends a blank summary to the SCR (Patient opted out)

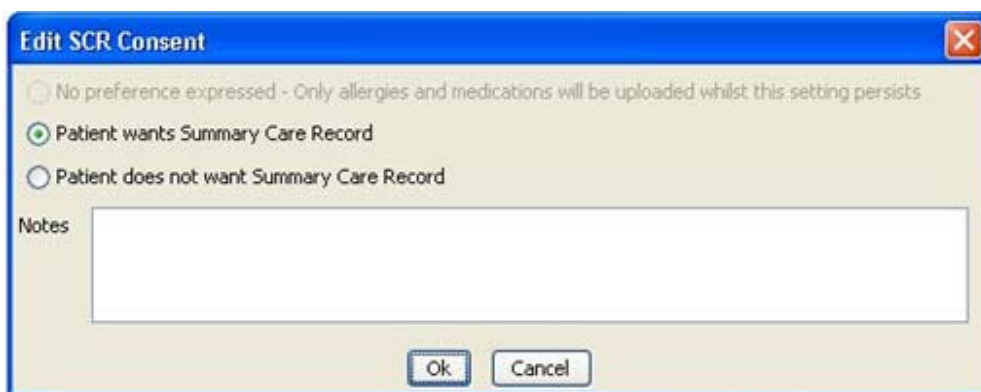
It is possible to switch between explicit consent (93C2.) and opt out (93C3.) by adding the appropriate Read code. Codes that record patient consent preferences should not be deleted from a patient's record for the purpose of changing a patient's consent preference. Section 4.4 describes the options available to patients where their consent preferences have changed.

TPP SystemOne

Patient preference can be set by either using the radio buttons on the SCR consent management screen or by adding the relevant CTV3 code. The most recent preference that is present in the system is used to control the flow of information to the SCR.

The setting of 'The patient wants to have a Summary Care Record' (CTV3 code XaKRx) should only be used where the patient has explicitly consented to have an SCR with the potential for additional information to be added to their record. Under this setting Reason for Medication will automatically be sent to the SCR where a problem or diagnosis is linked to a medication.

Managing patient preferences using the consent management screen



The default setting is 'No preference expressed'. Once a preference has been set you **cannot** revert back to 'no preference expressed' using the radio buttons as this option is greyed out. It is possible to switch between 'The patient wants a Summary Care Record' and 'The patient does not want a Summary Care Record' and vice versa using the radio buttons.

Managing patient preferences using CTV3 codes

CTV3 codes can be used to set patient preferences using the following:

Consent Preference	CTV3	Code Rubric	System Action
The patient wants to have a Summary Care Record (explicit consent)	XaKRx	Consent given for upload to national shared electronic record	Allows additional information to be sent to the SCR
The patient does not want to have a Summary Care Record (opt out)	XaKRy	Refused consent for upload to national shared electronic record	Sends a blank summary to the SCR (Patient opted out)

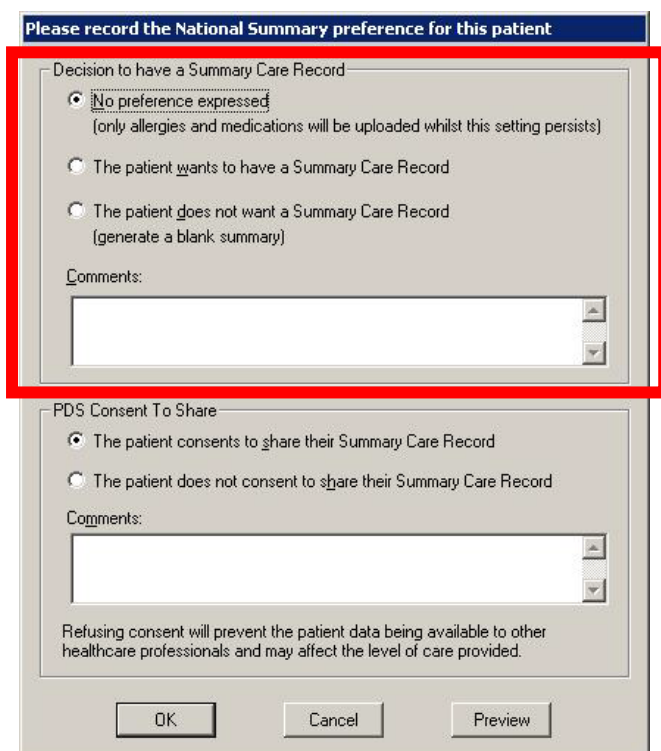
It is possible to switch between explicit consent (XaKRx) and opt out (XaKRy) by adding the appropriate code. Codes that record patient consent preferences should not be deleted from a patient's record for the purpose of changing a patient's consent preference. Section 4.4 describes the options available to patients where their consent preferences have changed.

INPS Vision 3

Patient preference can be set by either using the radio buttons on the consent management screen or by adding the relevant READ Code. The most recent preference that is present in the system is used to control the flow of information to the SCR.

The setting of 'The patient wants to have a Summary Care Record' (Read code 93C2.) should only be where the patient has explicitly consented to have an SCR with the potential for additional information to be added to their record. Under this setting Reason for Medication will automatically be sent to the SCR where a problem or diagnosis is linked to a medication.

Managing patient preferences using the consent management screen



The screenshot shows a dialog box titled "Please record the National Summary preference for this patient". It is divided into two main sections:

- Decision to have a Summary Care Record:** This section contains three radio buttons:
 - No preference expressed (only allergies and medications will be uploaded whilst this setting persists)
 - The patient wants to have a Summary Care Record
 - The patient does not want a Summary Care Record (generate a blank summary)
 Below the radio buttons is a "Comments:" field with a text input area and a scroll bar.
- PDS Consent To Share:** This section contains two radio buttons:
 - The patient consents to share their Summary Care Record
 - The patient does not consent to share their Summary Care Record
 Below the radio buttons is another "Comments:" field with a text input area and a scroll bar.

At the bottom of the dialog box, there are three buttons: "OK", "Cancel", and "Preview". A red rectangular box highlights the "Decision to have a Summary Care Record" section.

The default setting is 'No preference expressed'. It is possible to switch between 'The patient wants to have a Summary Care Record' and 'The patient does not want to have a Summary Care Record' and vice versa using the radio buttons.

Once a preference has been set you **can** revert back to implied consent using the radio buttons. This will end date the corresponding Read code in the patient's record. **It is not recommended that any patients are reverted back to a position of implied consent once a preference has been expressed.**

Managing patient preferences using Read codes

Read codes can be used to set patient preferences using the following:

Consent Preference	Read 2	Code Rubric	System Action
The patient wants to have a Summary Care Record (explicit consent)	93C2.	Consent given for upload to national shared electronic record	Allows additional information to be sent to the SCR
The patient does not want to have a Summary Care Record (opt out)	93C3.	Refused consent for upload to national shared electronic record	Sends a blank summary to the SCR (Patient opted out)

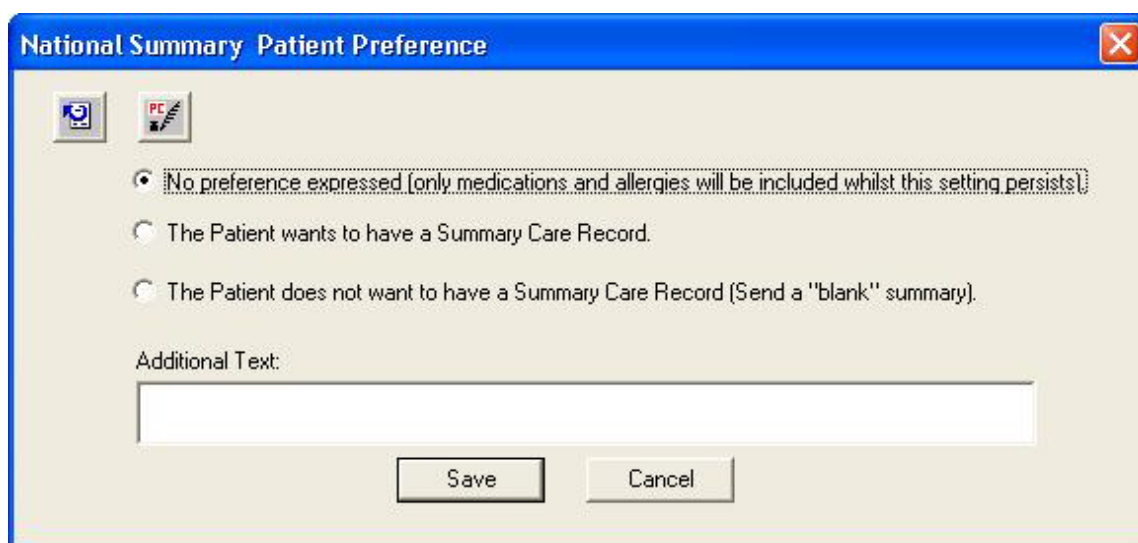
It is possible to switch between explicit consent (93C2.) and opt out (93C3.) by adding the appropriate Read code. Codes that record patient consent preferences should not be deleted from a patient's record for the purpose of changing a patient's consent preference. Section 4.4 describes the options available to patients where their consent preferences have changed.

iSOFT Synergy

Patient preference can be set by either using the radio buttons on the consent management screen or by adding the relevant READ Code. The most recent preference that is present in the system is used to control the flow of information to the SCR.

The setting of 'The patient wants to have a Summary Care Record' (Read code 93C2.) should only be used to confirm that the patient has explicitly consented to have an SCR with the potential for additional information to be added to their record. Under this setting Reason for Medication will automatically be sent to the SCR where a problem or diagnosis is linked to a repeat medication.

Managing consent preferences using the consent management screen



The default setting is 'No preference expressed'. It is possible to switch between Explicit Consent and Dissent and vice versa using the radio buttons.

Once a preference has been set you **can** revert back to implied consent using the radio buttons. **It is not recommended that any patients are reverted back to a position of implied consent once a preference has been expressed.**

Managing consent preferences using Read codes

Read codes can be used to set patient preferences using the following:

Consent Preference	Read 2	Code Rubric	System Action
The patient wants to have a Summary Care Record (explicit consent)	93C2.	Consent given for upload to national shared electronic record	Allows additional information to be sent to the SCR
The patient does not want to have a Summary Care Record (opt out)	93C3.	Refused consent for upload to national shared electronic record	Sends a blank summary to the SCR (Patient opted out)

It is possible to switch between explicit consent (93C2.) and opt out (93C3.) by adding the appropriate Read code. Codes that record patient consent preferences should not be deleted from a patient's record for the purpose of changing a patient's consent preference. Section 4.4 describes the options available to patients where their consent preferences have changed.

Appendix C: Factsheet for GP Practices (where the new SCR consent codes are not yet activated) supporting patients who want to opt back into the Summary Care Record after previously opting out

This guidance is **only** for GP Practices where they have **not yet** been notified by their systems supplier that the new SCR consent codes are activated i.e. can recognise and control the flow of information to the SCR. It provides advice to help GP practice staff support patients who want to opt back into the Summary Care Record after previously opting out.

1. To opt a patient back into the Summary Care Record you will need to set the patient to 'The patient wants a Summary Care Record' on your IT system (either in the SCR Consent Management screen or by adding the appropriate code 93C2 or XaKRX).
2. This will mean that additional information can be sent to their Summary Care Record if the patient and their GP agree and 'Reason for Medication' could be sent automatically if present in the patient's GP record.
3. You should explain this to the patient and if they are happy, change the setting on their record.
4. If the patient is not happy that this additional information could be sent to their SCR, you should advise them to remain opted out for the time being, until the new codes are activated in your GP IT system.

Further information can be found in the SCR GP Practice Guide at:

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/gppracinfo>

Appendix D: Security of Data

The SCR uses stringent security measures to safeguard the security of patient data. GP practice staff may get questions from patients regarding the security of their data that will be held on the SCR. The following points are relevant:

- By law, everyone working for, or on behalf of, the NHS must respect patient confidentiality and keep all information about patients secure. This duty of confidentiality applies equally to existing electronic and paper records, and the SCR.
- The SCR adheres to the NHS Care Record Guarantee for England and has been designed to fulfil all of the guarantees detailed within. This guarantee explains how the NHS will collect, store and allow access to patients' electronic records, and details a patient's choices. Copies are available to download from <http://www.nigb.nhs.uk/guarantee/2009-nhs-crg.pdf>

Controlling access:

- **Access by Patients**

Patients can ask to see what information an NHS organisation holds about them. This is called a Subject Access Request and is part of the Data Protection Act 1998. The Care Record Guarantee for the NHS also stipulates that if a patient believes that their information has been viewed inappropriately, it will investigate the claims and report back to the patient if they are substantiated. Either of these patient queries can be sent to individual NHS organisations or to the Department of Health.

Patients will also have the option to view their SCR at any time using HealthSpace. They will be able to check it for accuracy and record their preferences, for example, how they wish to be communicated with. If a patient believes that there is an inaccuracy in their record, they have the right to ask for it to be changed or, if agreement on the requested change cannot be reached, to ask that a statement be added saying that they disagree with their record. This will be done in accordance with existing guidelines for amending patient records.

- **Access by Authorised Healthcare Staff**

Authorised healthcare staff can only access patient data after they have satisfied robust access control mechanisms. These include:

- Physical controls – to access a SCR healthcare staff must have a NHS Smartcard. This provides what is known as two factor authentication i.e. a physical component is needed as well as a pass code. Rigorous processes are in place around the issuing of smart cards. Staff need to be sponsored and have ID checked before they are issued with a Smartcard.
- Controlling access for viewing records - to view an SCR healthcare staff must be involved in the patient's care - referred to as a Legitimate Relationship (LR) - before their record can be viewed. For example, a clinician treating a patient at an Emergency Department would be able to claim a Legitimate Relationship with that patient and therefore would be able to view that patient's record.
- Controlling access to the content that can be viewed - Role Based Access Control (RBAC) limits what functions can be used by a particular user and is set locally. For example, RBAC controls whether a user can see demographic information or clinical information.

The measures being used by the NHS for the protection of patient confidentiality have been scrutinised and approved by the Information Commissioners Office.

- **Monitoring Access**

In order to ensure that access to patient records is appropriate, audit trails are created when a patient's record is accessed. Alerts will be triggered automatically if there is a chance that an access may be inappropriate both to deter misuse of access privileges and to report any misuse when it occurs. When access is not justifiable, someone in the NHS organisation responsible for overseeing patient confidentiality – known as the Caldicott Guardian or Privacy Officer – will take action. This may include disciplinary procedures, and informing the patient where appropriate.

Further information on SCR Information Governance can be found at <http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/ig>

Appendix E: Good Practice Guidelines for GP Electronic Patient Records v4 (2011)

The Royal College of General Practitioners, British Medical Association and Department of Health have recently published Good Practice Guidelines for GP electronic patient records. These guidelines provide professional authoritative guidance to support GP practices develop, maintain and use electronic patient records. The following sections of the guidelines may be particularly useful to GP practices that are live or planning to go-live with the SCR:

- Chapter 6 High Quality Patient Records
- Chapter 8a The Personal Demographics Service (PDS)
- Chapter 8e The Summary Care Record and Emergency Care Summary
- Chapter 8f High Quality Medication Records and the Electronic Prescription Service
- Chapter 9 A pathway to good paperless practice

The 'Good Practice Guidelines for GP Electronic Patient Records' can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125310